GEORGIA CRIME VICTIMS COMPENSATION PROGRAM
104 Marietta Street, NW • Suite 440 • Atlanta, GA • 30303-2743
404/657-2222 • 800/547-0060 • 404/463-7652 (Fax) • 404/463-7650 (TTY)

SERIOUS MENTAL AND EMOTIONAL TRAUMA (SMET) VERIFICATION FORM

The Criminal Justice Coordinating Council (CJCC) is responsible for administering the State of Georgia's Crime Victim Compensation Program (CVCP). Recently, a crime victim, who is now a patient under your care, submitted a claim indicating that they suffered a serious mental or emotional trauma relating to a crime. In order to administer funds, CJCC is required pursuant to O.C.G.A. §17-15-2 to have documentation by a licensed mental health professional validating the serious mental or emotional trauma. To assist the CVCP in determining eligibility, we would appreciate your assistance in providing the below information so the CVCP can make the best decision regarding this claim.

Patient/Victim

Name: _____ Last 4 of SSN: _____

Address: _____ DOB: _____/_____/_____

Date of Crime: _____/_____/_____ Claim Number: _____

1. In your professional opinion, did this client suffer a serious mental or emotional trauma as a result of the crime that occurred on the date indicated above? Yes ☐ No ☐
2. If YES, please describe the nature of the serious mental or emotional trauma: _____

_____

_____

3. What is the diagnosis? (Please use the DSM diagnostic codes and categories. All Axes appropriate must be completed.)

	Code	**Category**
Axis I:	_____:	_____
Axis II:	_____:	_____
Axis III:	_____:	_____
Axis IV	_____:	_____
Axis V:	_____:	_____

I, the undersigned, do hereby certify that the expenses claimed herein are for remedial treatment of the victim for serious mental or emotional trauma directly related to the victimization. I understand that completion of this form only helps in the investigation of the claim, and that this does not guarantee that the Crime Victims Compensation Board will make payments for the services rendered. **If a claim is determined to be eligible, any payments beyond <u>one</u> session will require the completion of a Psychological Service Report before additional payments can be considered.**

_____ Date _____/_____/_____
Signature of Counselor/Therapist

_____
License Number/Name of Board

Subscribed before me this _____ day of _____, _____

_____ My Commission expires _____, _____
Notary Public